Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS639HOS	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE HOSPITAL AND MEDICAL CENTER	3186 S MARYLAND PKWY LAS VEGAS, NV 89109

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S 156 SS=G	NAC 449.332 Discharge Planning 14. If identified in a discharge plan, referral of a patient to outpatient services or transfer of the patient to another facility must be accomplished in a manner that meets the the identified needs of the patient, including the sharing of necessary medical information about the patient with the receiving service or facility. This Regulation is not met as evidenced by: Based on record review and interview, facility staff discharged a patient that needed additional care in an unsafe/improper manner. Patient #3 was transferred with blunt head trauma to the facility at 2:42 PM on 12/30/09. Patient #3's file contained several indications he needed an ENT consult. A physician wrote an order to transfer the patient to a second facility for this purpose on 1/1/10. On 1/2/10, a physician note indicated a case manager was working on an ENT consult. On 1/3/10, a physician note indicated the patient was waiting for a transfer to the second facility for an ENT evaluation and another indicated a case manager was working on obtaining an ENT evaluation. A third note indicated "here vs. transfer [to the second facility] for evaluation." On 1/4/10, a physician noted the lack of ENT availability at the facility and noted the second facility would not accept a transfer because the patient lacked insurance. The physician offered to discharge the patient with directions to go to the emergency department of the second facility. On 1/4/10, a physician noted two different times to discharge the patient once case management gave the patient bus/taxi fare to get to the second facility. The facility discharged the patient on the morning of 1/5/10. The discharge diagnoses included seizures vs. syncope, alcohol use, tobacco dependence, fall, traumatic brain injury, right temporal bone injury,	S 156	Tag S156 Sunrise Hospital has thoroughly reviewed this deficiency. Please see the corrective actions below: a.) The referenced patient is no longer a patient at the facility and therefore no corrective actions can be accomplished for this patient. b.) This deficiency could potentially affect any patient admitted to the hospital who has been identified in a discharge plan as needing a referral to outpatient services or transfer to another facility. c.) The following measures have been put into place and systematic changes initiated to ensure the deficient practice will not recur. Policies regarding acute care transfers and discharge planning were reviewed. Policy #ADT0106 has been revised to incorporate language clarifying the staff member's responsibility and notification process when an acute to acute transfer order has been provided by a physician. **(Exhibit A)** Additional language has been added to Policy #ADT0102 to specify initiation of the Chain of Command process to ensure safe discharge. **(Exhibit B)** Minor revisions were made to Policy #HIM013 to provide clarification regarding operational processes related to release of information. **(Exhibit C)** These policy revisions will be presented for approval at the April 9, 2010 Facility Policy and Procedure Committee meeting. The Chief Medical Officer developed a communication memo to all medical staff members referencing the Medical Staff	

Accepted as presented 4/14/10

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Sylvia Young TITLE CEO (X6) DATE 4/8/2010

S FORM 6899 8N6R11

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S 156	Continued From page 1 right hemotympanum, posttraumatic intracranial hemorrhage, resolved leukocytosis, and improved headache. The second facility admitted the patient at 2:08 PM in its emergency department on 1/5/10. The record indicated the patient brought himself to the second facility without any documentation from the facility. At 2:45 PM on 1/5/10, the patient indicated the following: "I was instructed to come to [the second facility]. I was a patient at [the facility]. I was told there was no ENT doctor at [the facility], so they discharged me after 6 days and paid for the taxi cab they sent me here in." The facility's director of case management denied this ever occurred, but the facility's discharge instructions indicated someone at the facility provided a taxi voucher. The second facility admitted the patient at 3:58 PM on 1/5/10. A physician diagnosed the patient with right temporal bone fracture, right facial nerve palsy (new diagnosis), and seizure disorder. Neurology consulted and eventually cleared the patient for discharge with Valproic Acid. ENT consulted and recommended steroids to be tapered after a week and to follow up in Lied Clinic. The patient was discharged with Prednisone 10 mg, Dilaudid 2 mg, Ofloxacin eardrops, Valproic Acid, and Artificial Tears. The second facility requested records from the facility on 1/5/10 and 1/8/10. The patient stayed 5 days at the second facility and was discharged on 1/10/10. On 2/19/10 at 9:30 AM, Physician #1 felt discharging Patient #3 enabled Patient #3 to get to the second facility more quickly, and Patient #3 was relatively stable. Physician #1 indicated it was difficult to unrealistic to secure an ENT consult at the facility despite an active roster of ENT physicians. Physician #1 claimed some	S 156	Bylaws and Rules and Regulations regarding the physician specific responsibilities regarding consultations; emphasizing the importance to provide complete documentation which identifies the ordering physicians' attempts to obtain consulting providers and the response relative to participation and care. The physicians were informed to initiate the chain of command through medical staff leadership and administration. Information regarding the physician role and responsibility for transfers to acute care facilities as referenced in Policy #ADT0106 was reiterated. This communication will be distributed to all active Medical Staff members via FAX blast by April 16, 2010. This communication will also be incorporated in the next quarterly physician newsletter published before May 31, 2010. **(Exhibit D)** A Healthstream online education module has been developed. An Adult, Pediatric and Labor and Delivery version were customized to reference their appropriate online documentation screens. **(Exhibit E)** This education reviews and reiterates the hospital policies regarding Safe Discharge Planning and Chain of Command. This education will be required for all case management and direct patient care nursing staff; and require a post test to be completed with a passing score of 80%. This class will be assigned to all appropriate personnel for completion by May 15, 2010. The Taxi Voucher log was modified on April 8, 2010 to assist the public safety officer in reviewing and processing of requests for vouchers. A reminder statement has been included on the log that reads	

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S 156	Continued From page 2 physicians were contacted to consult, but he failed to indicate physicians by name. A list of active, credentialed physicians indicated the facility had associations with 16 ENT physicians. On 2/19/10 at 9:45 AM, each physician's active status was verified with the supervisor for physician credentialing. Ten of the physicians were contacted. Eight of the physicians indicated they were never asked to consult on Patient #3's case. The other two physicians were on vacation during Patient #3's stay. One of these two physicians, Physician #3 on vacation, indicated he did not have to see any patient if and when asked. The facility had a reciprocal facility transfer agreement in effect with the second facility at the time of the aforementioned event. According to the agreement, the facility only transferred a patient due to medical necessity. Medical necessity was defined as services required to be provided to a patient with an emergency medical condition which are provided at the receiving facility but are not provided at the transferring facility for ANY patient and which are not provided to any patient at any other facility within the transferring facility's system. According to the second facility, the neurologist for Patient #3 indicated the ENT consult was viewed as non-emergent in this case, and the second facility denied the transfer as a result. Therefore, the facility would have violated the reciprocal agreement by transferring the patient. According to facility policy #ADT0106, and last revised in May 2007, "transfer to another facility may occur if a particular service is not provided at [the facility]. The policy failed to allow for transferring a patient because physicians refused consults to see patients or because facility personnel failed	S 156	"Patients should not be discharged and transported to another healthcare facility without approval of the house supervisor." An educational flyer has been developed for the Public Safety Department that reiterates the criteria for providing Taxi Vouchers for discharged patients. In addition, staff has been instructed to clarify any requests not meeting criteria through the chain of command. **(Exhibit F)** Inservices were provided to the Public Safety officers beginning April 6, 2010 and will be completed by April 30, 2010. Staff who were directly involved with this deficiency will be individually coached by their supervising manager by April 30, 2010. Mandatory Employee Town Hall Forums will be conducted from April 6, 2010 until April 27, 2010. These sessions are presented by the Senior Administrative Team. The focus of the presentation is the recommitment to our professional standards program, which reflects behavioral standards and expectations for all employees. This program incorporated modeling of our patient service expectations and promoting patient advocacy. Emphasis was placed on initiation of the chain of command to assure patient safety and quality of care. **(Exhibit G)** d.) The process to assure patients admitted to the hospital, who have been identified in a discharge plan as needing a referral to outpatient services or transfer of the patient to another facility, will be monitored. An audit consisting of 25 "acute to acute" transfer orders per month for 3 consecutive months will be reviewed to assure	

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S 156	Continued From page 3 to ask physicians to provide needed consults. Ultimately, the facility failed to provide the care recommended, and failed to discharge/transfer the patient properly. The facility discharged the patient knowing the patient needed additional care the facility was capable of providing. The second facility eventually referred Patient #3 to one of the same eight ENT physicians facility personnel never contacted to request a consult (Physician #2). Scope: 1 Severity: 3	S 156	compliance with completion of appropriate transfer forms and required documentation. This review will include the assessment of the mode of transfer that is individualized and appropriate to the identified patient needs. Additionally, review of the relevant patient medical information provided to the receiving facility in accordance to the policy timeframes will be included in this audit to assure continuity of care. A monthly audit of 25 records for patients identified in the discharge plan as needing a referral to outpatient services will be conducted for a 3 month period. The record will be reviewed to assure the referral was obtained and arrangements appropriately provided in compliance with the facility policy to include completion of required documentation. The review will include the assessment to determine if relevant medical information was provided to the patient or referral entity as appropriate, in accordance to the policy timeframes and to assure continuity of care. An audit of the taxi voucher log will be reviewed monthly for 3 consecutive months. Each entry will be reviewed to assure taxi vouchers have been issued according to criteria, and notification process initiated for requests not meeting criteria or needing clarification. e.) Responsible Party is the CEO. f.) The date for completion of these corrective actions will be May 31, 2010 **Tag S300** Sunrise Hospital has thoroughly reviewed this deficiency. Please see the corrective actions below:	
S 300 SS=F	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide individualized care based on the assessed needs of 2 of 3 patients by failing to contact physicians to provide an ENT consult (Patient #3) and failing to administer ordered Benadryl for at least an hour and forty-four minutes after a Vancomycin reaction (Patient #2).	S 300		

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S 300	Continued From page 4 Severity: 2 Scope: 3	S 300	a.) The referenced patient is no longer a patient at the facility and therefore no corrective actions can be accomplished for this patient. b.) This deficiency could potentially affect any patient admitted to the hospital. c.) A Healthstream online education module has been developed. **(Exhibit H)** The module contains a review of the medication administration policy with focus on the administration of PRN medication orders. Information is provided regarding the importance of referencing any clinical parameters that may be included in the order. The importance of documenting the assessment of the patient symptoms related to the PRN order and timeliness of administration was emphasized. This education will be mandatory for all staff that administer medications and will also require a post test to be completed with a passing score of 80%. The Chief Medical Officer developed a communication memo to all medical staff members referencing the Medical Staff Bylaws and Rules and Regulations regarding the physician specific responsibilities regarding consultations; emphasizing the importance to provide complete documentation which identifies the ordering physicians' attempts to obtain consulting providers and the response relative to participation and care. The physicians were informed to initiate the chain of command through medical staff leadership and administration. Information regarding the physician role and responsibility for transfers to acute care facilities as referenced in Policy #ADT0106	

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S 300	Continued From page 4 Severity: 2 Scope: 3	S 300	was reiterated. This communication will be distributed to all active Medical Staff members via FAX blast by April 16, 2010. This communication will also be incorporated in the next quarterly physician newsletter published before May 31, 2010. **(Exhibit D)** Mandatory Employee Town Hall Forums will be conducted from April 6, 2010 until April 27, 2010. These sessions are presented by the Senior Administrative Team. The focus of the presentation is the recommitment to our professional standards program, which reflects behavioral standards and expectations for all employees. This program incorporated modeling of our patient service expectations and promoting patient advocacy. Emphasis was placed on initiation of chain of command to assure patient safety and quality of care. **(Exhibit G)** d.) The monitoring to assure that medications are administered timely and appropriately within parameters will be accomplished through our routine monitoring of medication events and an additional audit of 25 PRN medication orders per month for 3 consecutive months that have specific parameters. A monthly audit of 25 records, in which an attending physician has identified a patient's need to secure consultation of a specialist provider, will be conducted for a 3 month period. Documentation will be reviewed to assess compliance with physician responsibility as outlined in the medical staff governance documents. This audit will include a review of documentation by the attending physician regarding interventions	

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S 300	Continued From page 4 Severity: 2 Scope: 3	S 300	in obtaining consultation, documentation which identifies their attempts to obtain consulting providers and the response relative to participation and care, timely initiation of chain of command as appropriate, and initiation of an acute to acute care transfer as warranted. e.) The responsible party is the Chief Executive Officer. f.) The date for completion of these corrective actions will be May 31, 2010. All monitoring will be reported to the Quality Care/Patient Safety Committee and forwarded to the MEC and the Board of Trustees.	